EST. 1999
PRAIRIE CROSSING
CHARTER SCHOOL
CREATING NATURAL LEADERS

PRESCRIPTION MEDICATION PHYSICIAN AUTHORIZATION FORM

(Only one medication per form) ***This form must be renewed at least once a year.***

Student's name: _____ Grade: _____ Birth date: _____

Diagonosis:_____

Name of medication: _____ Duration of medication: _____

Dosage: _____ Time to be taken: _____

Are there any side effects to this medication? No Yes If yes, please specify: _____

_____

Self-Administration Consent (if applicable)

I certify that _____ has been instructed in the use and self-administration of the medication described above. He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

Prescriber's Signature: _____ Date:_____
(Original signature or signature/address stamp only)

_____

I give permission for my child, _____, to carry the medication described above. I will notify the school of changes in medication for my child's condition. I indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the student.

_____ _____
Parent/Guardian Signature Date

1531 Jones Point Road
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